Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DENISE BASKIND, MD
3100 TIMMONS LANE #250
HOUSTON, TX 77027

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-10-3932-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier failed to properly pay this injured workers Designated Doctors Exam even after it was sent back as a request for reconsideration."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of dispute was placed in carrier rep box on May 13, 2010 with no response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 08, 2010	99456-WP-W5	$300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of Benefits dated April 7, 2010
   - CAC-W1 – WORKERS' COMPENSATION STATES FEE SCHEDULE ADJUSTMENT
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDNANCE TO THE TEXAS MEDICAL FEE GUIDELINE.

   Explanation of Benefits dated April 7, 2010
   - CAC-W4– NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
   - 891 – THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERATION

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The provider billed the amount of $1,100.00 for CPT code 99456-W5-WP for DD Examination for Maxmimum Medical Improvement (MMI) and Impairment Rating (IR). Review of the documentation supports that MMI was assigned and two body areas were rated. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. To determine reimbursement for an IR, the method of calculating IR and the number of body areas/conditions is reviewed. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a), the MAR for a 1st musculoskeletal area IR using Range of Motion (ROM) on right shoulder (upper extremity) is $300.00. Documentation supports lumbar and cervical rated per Diagnosis Related Estimates (DRE) Category II method. Per Texas Administrative Code §134.204(j)(4)(C)(i)(I), lumbar and cervical are one part of one area, the spine. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using DRE $150.00. The combined MAR for the MMI/IR exam is $800.00 which has already been paid, there is no additional due.

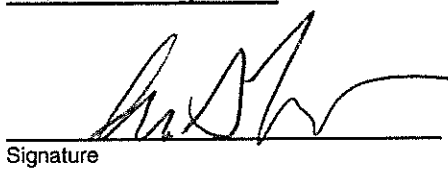
Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature



Signature | Gregory Fournerat, Medical Fee Dispute Resolution Officer | November 10, 2011, Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.